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RESIDENTIAL ELEVATOR/ WHEELCHAIR LIFT INSPECTION FEE REDUCTION APPLICATION

1. Name and address of the person in control of the building or domicile where elevator or wheelchair lift is located.

Tel: _____

2. Building/Domicile Address where elevator or wheelchair lift is located.

3. Check the type of device: ☐ Residential Elevator ☐ Wheelchair lift

4. Tag # _____

5. State the name, address, and telephone number of the licensed physician attesting to the medical necessity of the elevator or wheelchair lift.

Tel: _____

6. Attach a letter from a licensed physician attesting to the medical necessity of the elevator or wheelchair lift.

PLEASE NOTE: The Board of Elevator Regulations, in its discretion, may hold a hearing on your requested fee reduction or may decide your exemption without a hearing based upon the information you submit. If accepted, the inspection fee will be \$100.00. You should therefore include all relevant information with your application. At minimum, a physician's note is required. In the event that you are aggrieved by a decision of the Board where no hearing was held, you may request a hearing before the Board. All hearings will be held in accordance with G.L. c. 30A and 801 CMR 1.02. Any person aggrieved by a decision of the Board after hearing may appeal pursuant to G.L. c. 30A.

Name

Address

City/Town

State

Zip Code

I hereby attest, under the pains and penalties of perjury that the information provided above, and attached to this application, is accurate to the best of my knowledge.

Signature

Date

FOR BOARD USE ONLY:

Approved _____ Denied _____

By: _____ - on behalf of the Board of Elevator Regulations Date: _____